STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Chester River Manor Corp	200 Morgnec Road Chestertown, MD 21620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent Residents. This was found evident in 1 (Resident #112) out of 1 residents reviewed for Activity of Daily Living (ADL) care during the recertification/complaint survey.The findings include:On 12/15/25 at 8:08 AM, the surveyor reviewed intake #361829. The intake alleged that Resident #112 only received one shower while a resident at the facility.On 12/15/25 at 1:28 PM, the surveyor requested all shower documentation for Resident #112 stay from mid-March of 2025 to mid-April of 2025.On 12/16/25 at 7:36 AM, the surveyor conducted an interview with Unit Manger #4. During the interview UM #6 presented skin check sheets for Resident #112 however, there was no notation or documentation on the skin sheets that indicated that a shower was provided. The UM stated that the skin sheets are done on the 2 assigned shower days each week. The UM stated she would look to see if there was additional documentation.On 12/16/25 at 7:55 AM, the surveyor conducted a follow-up interview UM #6. During the interview the surveyor reviewed the documentation provided by UM #6. On review of the March 2025 Point to Care (POC) (a place where Geriatric Nursing Assistance (GNA)s document the care they provided) it was marked that Resident #112 was dependent or needed substantial to maximal assistance with shower/bathing. The section that documented the assistance needed to transfer to the Resident to the shower had one date marked, 3/24/25. On this day it was documented that Resident #112 was dependent on staff to help transfer to the shower. No other days documented that Resident #112 was assisted to and then showered. UM #6 agreed there was limited documentation that demonstrated that multiple showers were completed. She explained that in the past transfers and showers were prompted on an as needed basis and not on the scheduled shower days. She further stated that currently the shower days are scheduled on the POC and documentation is prompted on scheduled shower days. She confirmed that there was no additional documentation to demonstrate Resident #112 received more than one shower.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review, review of facility's policy, and interviews it was determined that the facility failed to identify and provide appropriate interventions for a resident's condition. This was found evident of 1 (Resident #112) out of 1 resident reviewed constipation/diarrhea during the recertification/complaint survey. The findings include:On 12/15/25 at 8:08 AM, the surveyor reviewed intake #361829. The intake alleged that the facility did not monitor or administer bowel regimen medications appropriately.On 12/16/25 at 12:30 PM, the surveyor reviewed Resident #112's Medication Administration Record (MAR) for March of 2025. Both Miralax (an over-the-counter osmotic laxative used to help with constipation) and Senna (over-the-counter stimulating laxative used to prevent constipation) were ordered to be given. The order for Miralax was daily and Senna was for two pills twice a daily. On 3/19/25 the Miralax was discontinued and Senna was written to be given every other day and decreased to one pill. Additionally, Imodium (a medication given to help with diarrhea) was ordered on 3/19/25, written to use as needed (for 3 days), with the indication for loose bowel movements. One dose was given on 3/19/25. The surveyor also noted that a Bisacodyl suppository was also ordered on admission and written to be given rectally every 48 as needed. No administration of the suppository was noted in March of 2025.Next the surveyor review of bowel movement log provided by the facility for Resident #112. The review revealed that Resident #112 had no bowel movement documented from 3/25/25- 3/29/25 (5 days). The surveyor noted that during this time frame the Resident's bowel regimen medications had recently been decreased and an antidiarrheal was given.On 12/16/25 at 12:32 PM, the surveyor interviewed Unit Manager #4. During the interview the surveyor asked what the protocol would be if a Resident went 5 days without having a bowel movement. UM #4 stated that she would expect the provider would be notified and a bowel protocol to be ordered. The surveyor reviewed the time frame that Resident #112 was documented as not having a bowel movement. UM #4 stated that she would review the notes because sometimes the bowel movements can be captured there.Next, the surveyor reviewed the progress notes. The review revealed nursing notes on 3/25/25 at 1:22 PM, 3/27/25 at 12:03 PM, and 3/29/25 at 7:03 AM that all documented Resident #112 had active bowel sounds in all four quadrants along with the comment constipation noted.On review of the facility's Bowel Management Protocol the policy states; Residents will be monitored daily for bowel movements (BM) and have the bowel protocol PRN (as needed) initiated after it's identified that an intervention is required. In the procedure it states; The Geriatric Nursing Assistant (GNA) will document in Point of Care (POC) all resident bowel activity. Alert listing will be checked for no bowel activity in 72 hours. Bowel protocol will be initiated if ordered by a Medical Doctor (MD). Results of the protocol will be documented in electronic health record.At the time of exit no additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical record review and staff interview it was determined that the facility failed to provide pain management as prescribed. This was evident for 1 (Resident #109) of 1 resident reviewed for pain management during the recertification/complaint survey.The findings include:Resident #109's Representative (RP) filed complaint #2580649 regarding the resident's pain management. The RP stated that the resident had been prescribed by the medical personnel pain medication for the large pressure ulcers (PU) and the pain incurred when the resident received treatment for these PU. On 12/15/2025 at 1:00pm, after reviewing the medical record and an interview with the Director of Nursing it was discovered that Resident #109 was not receiving the Tramadol medication every 8 hours as prescribed and the 2 pm dose was signed off on the Medication Administration Record (MAR) as being given but when the Medication Administration Record was compared with the Narcotics Record it was evident that the Tramadol had not been given. The missing Tramadol dates were 8/4-8/8/2025.When the Director of Nursing was informed of the surveyor's concern in an interview on 12/15/2025 at 2pm, she stated that she had spoken with Employee #28 who thought that he/she had signed the MAR in error and that he/she thought the resident had refused the 2:00 AM medication. When the progress notes were reviewed there was no note that supported that the resident had refused the 2:00 AM medication. During the interview, the DON was asked what the facility's expectations were for narcotic medication administration and they stated that the expectation was that medication was to be administered at the time ordered and if the resident refused, the refusal was to be documented in the progress notes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor record review, review of consultation notes and Resident and staff interviews, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete and accurate documentation. This finding was found to be evident in 4 (Resident # 6, #33, #59, and #112) out of 41 Residents reviewed for identifiable information in the Resident medical records during the recertification/complaint survey. The findings include: A Medication Administration Record (MAR) is a legal document used by healthcare professionals to track all medications administered to a Resident. It is a crucial component of a Resident's medical chart, serving to ensure patient safety, accountability, and communication among care teams. The purpose of the MAR is to ensure safe and accurate medication management by providing a clear, trackable history of every medication dose given or missed. A Care Plan is a written document that outlines a person's care needs and how they will be met. It's a key tool for health and social care professionals to ensure a Resident receives the right level of care. Care plans are usually created after care needs assessment and risk assessment, involving the person receiving care and their family. Care plans are used to guide health and social care professionals in delivering care and standardize evidence-based care. A Minimum Data Set (MDS) assessment is a comprehensive, federally mandated clinical evaluation for Residents in Medicare/Medicaid-certified nursing homes in the United States. The purpose is to provide a standardized, uniform assessment of Resident health status, identify problems, strengths, and preferences, and inform care planning and payment. MDS assessments are completed by trained nursing home staff upon admission, quarterly, annually, and whenever a Resident's condition significantly changes. Functional capabilities, cognitive status, health conditions, treatment, therapies, psychosocial well-being and discharge planning are assessed in the MDS process. 1) On 12/08/25 at 9:02 AM, the surveyor interviewed Resident #6. During the interview Resident #6 stated that he/she had not had any teeth in years. On 12/10/25 at 10:20 AM, the surveyor reviewed Resident #6's nursing admission assessment dated [DATE]. The assessment documented Resident #6 had an oral exam completed for this assessment. In a section titled, Describe Natural Teeth (if applicable) Resident #6 was coded, no decay. The Missing some or all Teeth option was left blank. Next the surveyor reviewed Resident #6's most recent Minimum Data Set (MDS) assessment dated [DATE]. In the oral dental assessment, there was a list that gave options to capture an abnormal evaluation. One option was, no natural teeth or tooth fragment(s) (edentulous) but this option was left blank. Resident #6 was coded as none of the above were present. On 12/10/25 at 10:47 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident #6's assessments were inaccurate. The DON stated she would look into the concern. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/25 at 11:02 AM, Director of Admissions Staff #7 confirmed that Resident #6 did not have teeth, and confirmed the assessments were inaccurate. On 12/10/25 at 11:11 AM, the surveyor interviewed the MDS coordinator Staff #17. During the interview Staff #17 stated that the oral/dental assessment is completed by looking at nursing, dietary and speech documentation and that it is not common practice for the MDS coordinator to do an oral examination. She further stated that she would code the oral/dental status based off the other disciplines assessments. She further stated that Resident #6 should have been coded edentulous. 2) On 12/15/25 at 10:33 AM the surveyor reviewed Resident #59's medical record. The review revealed that Licensed Practical Nurse (LPN) #23 wrote a progress note on 11/26/25 that stated the Nurse Practitioner (NP) saw Resident #59 and ordered Debrox for 5 days (11/26/26-12/1/25) and then instructed to flush the ear. Next the surveyor looked to find the corresponding NP note but was unable to find the note in Resident #59's electronic medical record. The last primary provider note in the electronic Medical Record was dated 10/26/25. The surveyor reviewed an additional note written by LNP #23 on 12/3/25. The note stated that Resident #59 continued to complain of left ear fullness and wax build up. It further stated that Resident #59 had been receiving the Debrox drops and after an ear flush there was minimal to no results. (last dose of Debox was given on 12/1/25) On 12/16/25 at 8:30 AM, the surveyor conducted an interview with Unit Manager #4. When asked about the note written on 12/3/25 that stated Resident #59's left ear was flushed, the surveyor asked if this was done by the LPN. UM #4 stated that she would look into it but believed a Nurse Practitioner (NP) saw Resident #59 that day. The surveyor reviewed the concern that the last note from the primary provider in Resident #59's medical record was from October 2025 even though it was documented in the progress notes that a provider saw Resident #59 after October 2025 date. The surveyor requested all primary provider notes from November and December of 2025 for Resident #59. On 12/16/25 at 10:37 AM, the surveyor conducted a follow up interview with UM #4. During the interview UM #4 stated that she had reached out to the providers and that they were uploading the notes into the electronic medical system. She further stated that the Medical Director saw Resident #59 yesterday and would provide the notes. The surveyor reviewed the provider's notes written by Nurse Practitioner (NP) #26. The notes were all created 12/16/25 and are as follows: Created on 12/16/25 at 10:34 AM for an effective date of 11/26/25 at 10:34 AM. Created on 12/16/25 at 10:35 AM for an effective date of 12/3/25 at 10:35 AM. Created on 12/16/25 at 10:56 AM for an effective date of 11/30/25 at 10:57 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/25 at 11:54 AM, the surveyor reviewed the concern that Resident #59's medical record was not completed and that multiple provider's notes were not timely written and not part of Resident #59's medical record. UM #4 agreed that the provider's notes should have been in Resident #59's medical record. 3) On 12/15/25 at 10:28 AM, the surveyor reviewed Resident #112's orders. The review revealed that Resident #112 had orders written on 3/12/25 for Physical Therapy (PT) to be provided 3-5 times per week. The surveyor requested PT notes for Resident #112's therapy treatment. Next the surveyor reviewed the PT sessions. Resident #112 worked with PT as follows: Week 1. 3/13/25 (TH), 3/17/25 (M), and 3/19/25 (W). Week 2. 3/24/25 (M), and 3/26/25 (W). Week 3. 3/27/25 (TH), 3/29/25 (Sat), and 4/2/25 (W). Week 5 4/6/25 (Sat), and 4/7/25 (M). On 12/16/25 at 8:51 AM, the surveyor conducted an interview with the Director of Rehabilitation Staff #5. During the interview the surveyor asked why Resident #112 was only seen twice in the 2nd week of therapy when the order was for 3-5 times. Staff #5 stated she would look into the issue and follow-up. On 12/16/25 at 10:07 AM, the surveyor conducted a follow-up telephone interview with Staff #5. During the interview Staff #5 stated that on 3/25/25 PT documented that Resident #112 was unavailable. The surveyor asked Staff #5 if it was protocol to make a second attempt if a resident was not available. The surveyor also reviewed with Staff #5 that Resident #112 had been available and worked with Occupational Therapy that same day. Staff #5 stated that it is the expectation for therapy to attempt to see the Resident a second time if they are unavailable at the first attempt. There was no documentation available to demonstrate why Resident #112 was not seen three times in his/her second week of rehab. 4) In an interview with Resident #33 on 12/8/2025 at 2:25 PM the surveyor asked Resident if he/she was taking a blood thinner medication and Resident stated, yes, I have had 2 heart attacks in the past. The surveyor conducted a record review of Resident #33's medical record on 12/11/2025 at 7:15 AM. The review of the medical record revealed that Resident #33 had an active, current physician order that stated, anticoagulant medication – monitor for discolored urine, black tarry stools, sudden severe headache, N&V (nausea and vomiting), diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or V/S (vital signs), nose bleeds every shift. Further review of the medical record revealed that Resident #33 did not have an active, current physician order for an anticoagulant medication (blood thinner). Additionally, review of Resident #33's medication administration records (MAR), care plans and Minimum Data Set (MDS) assessments did not indicate that Resident was currently taking an anticoagulant medication. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) at 8:35 AM on 12/11/2025 the surveyor conveyed that Resident #33 had an active, current physician order for monitoring of an anticoagulant medication, but the Resident was not currently taking an anticoagulant medication according to the documentation in the medical record. Resident #33 did not have an active, current physician order for the anticoagulant medication, the MARs did not have an anticoagulant medication listed, the plan of care did not have a care plan for anticoagulant medication, and the MDS assessments were not coded for Resident taking an anticoagulant medication. The Director of Nursing (DON) reviewed the physician orders, acknowledged the surveyor, and stated that Resident #33 was not currently prescribed an anticoagulant medication, and that the physician order for monitoring of the anticoagulant medication would be discontinued. No additional information was provided by the facility at the time of exit.